# TENNESSEE DEPARTMENT OF HEALTH

**Health Statistics**
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## JOINT ANNUAL REPORT OF HOSPITALS

## 2013

State ID 70223

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2013

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital Copper Basin Medical Center — Federal Tax I.D. # 62-1448752
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Polk
2. Address of Facility — Street 144 Medical Center Drive; City Copperhill; State Tennessee; Zip 37317-
3. Telephone Number (423) 496-5511 (Area Code Number)
4. Name of Chief Executive Officer Donald (First Name) Curtis (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Felicia Deal
   Telephone Number if different than above (423) 496-8153 (Area Code Number)
6. 25 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 10/01/2012 Ending Date 09/30/2013
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

| | NAME OF HOSPITAL | STATE ID | SATELLITE | OWN | OPERATE | OWN AND OPERATE |
|---|---|---|---|---|---|---|
| 1 | | | ☐ | ○ | ○ | ○ |
| 2 | | | ☐ | ○ | ○ | ○ |
| 3 | | | ☐ | ○ | ○ | ○ |
| 4 | | | ☐ | ○ | ○ | ○ |
| 5 | | | ☐ | ○ | ○ | ○ |

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

| 1. Government-Non-Federal | 2. Government-Federal | 3. Nongovernmental, not-for-profit | 4. Investor-owned, for-profit |
|---|---|---|---|
| ◯ 11 State | ◯ 17 Armed Forces | ◯ 20 Church-operated | ◯ 23 Individual |
| ◯ 12 County | ◯ 18 Veterans Admin. | ◉ 21 Other Nonprofit Corporation | ◯ 24 Partnership |
| ◯ 13 City | ◯ 19 Other, please specify | ◯ 22 Other not-for-profit, please specify | ◯ 25 Corporation |
| ◯ 14 City-County | | | |
| ◯ 15 Hospital district or authority | | | |

B. Is the hospital part of a health system? ◯ YES ◉ NO

If yes, please provide the name and location of the health system.

Name _____ City _____ State _____

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ◉ YES ◯ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

Copper Basin General Hospital District

E. Is the hospital a division of a holding company? ◯ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ◯ YES ◉ NO

G. Is the hospital managed under contract? ◯ YES ◉ NO If YES, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.

Name _____ City _____ State _____

Name _____ City _____ State _____

H. Is the hospital part of a health care alliance? ◯ YES ◉ NO (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name _____ City _____ State _____

Name _____ City _____ State _____

I. Is the hospital part of a health network? ◯ YES ◉ NO (see definition of network)

If yes, please provide the the name, city, and state of the network.

Name _____ City _____ State _____

Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

| | |
|---|---|
| ◉ 01 General medical and surgical | ◯ 07 Rehabilitation |
| ◯ 02 Pediatric | ◯ 08 Orthopedic |
| ◯ 03 Psychiatric | ◯ 09 Chronic disease |
| ◯ 04 Tuberculosis and other respiratory diseases | ◯ 10 Alcoholism and other chemical dependency |
| ◯ 05 Obstetrics and gynecology | ◯ 11 Long term acute care |
| ◯ 06 Eye, ear, nose and throat | ◯ 12 Other-specify treatment area |

B. Does your hospital own or have a contract with any of the following?

| | (1) Yes | (2) No | Specify one: 1) Own | 2) Contract | Number of Physicians | FTE Physicians |
|---|---|---|---|---|---|---|
| 1. Independent Practice Association | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 2. Group Practice Without Walls | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 3. Open Panel Physician-Hospital Organization (PHO) | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 4. Closed Panel Physician-Hospital Organization (PHO) | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 5. Management Services Organization (MSO) | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 6. Integrated Salary Model | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 7. Equity Model | ○ | ◉ | ○ | ○ | 0 | 0.0 |
| 8. Foundation | ○ | ◉ | ○ | ○ | 0 | 0.0 |

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
**Check all that apply.**

| | (1) Your Hospital | (2) Health System | (3) Health Network | (4) Alliance | (5) Joint Venture With Insurer |
|---|---|---|---|---|---|
| A. Health Maintenance Organization | (1) ☐ | (2) ☐ | (3) ☐ | (4) ☐ | (5) ☐ |
| B. Preferred Provider Organization | (1) ☐ | (2) ☐ | (3) ☐ | (4) ☐ | (5) ☐ |
| C. Indemnity Fee For Service Plan | (1) ☐ | (2) ☐ | (3) ☐ | (4) ☐ | (5) ☐ |

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? ◉ YES ○ NO
      1. How many do you contract with? 0
      2. Number of different contracts 0
   B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
      1. How many do you contract with? 0
      2. Number of different contracts 0

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.0 %

6. How many covered lives are in your capitation agreements? 0

SCHEDULE C - ACCREDITATIONS AND APPROVALS* State ID 70223

1. ACCREDITATIONS:

| | | |
|---|---|---|
| A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) | | |
| Date of most recent accrediting letter or survey 10/25/2012 | ◉ YES | ○ NO |
| If Yes, Is the hospital accredited under either/both of the following manuals: | | |
| 1. Comprehensive Accreditation Manual for Hospitals (CAMH) | ◉ YES | ○ NO |
| 2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) | ○ YES | ◉ NO |
| 3. Other manuals, please specify _____ | | |
| B. Commission on Accreditation of Rehabilitation Facilities (CARF) | | |
| Date of most recent accrediting letter or survey _____ | ○ YES | ◉ NO |
| C. American College of Surgeons Commission on Cancer | ○ YES | ◉ NO |
| D. American Osteopathic Association (AOA) | ○ YES | ◉ NO |
| E. TÜV Healthcare Specialists | ○ YES | ◉ NO |
| F. Community Health Accreditation Program (CHAP) | ○ YES | ◉ NO |

2. CERTIFICATIONS:

| | | |
|---|---|---|
| Medicare Certification | ◉ YES | ○ NO |

3. OTHER:

| | | |
|---|---|---|
| A. THA Membership | ◉ YES | ○ NO |
| B. Hospital Alliance of Tennessee, Inc. Membership | ○ YES | ◉ NO |
| C. American Hospital Association Membership | ◉ YES | ○ NO |
| D. American Medical Association Approval for Residencies (and Internships) | ○ YES | ◉ NO |
| E. State Approved School of Nursing: | | |
| Registered Nurses | ○ YES | ◉ NO |
| Licensed Practical Nurses | ○ YES | ◉ NO |
| F. Medical School Affiliation | ○ YES | ◉ NO |
| G. Tennessee Association of Public and Teaching Hospitals (TNPath) | ○ YES | ◉ NO |
| H. National Association of Children's Hospitals and Related Institutions (NACHRI) | ○ YES | ◉ NO |
| I. National Association of Public Hospitals (NAPH) | ○ YES | ◉ NO |

J. Other, please specify _____

Field is limited to 255 characters

1. CERTIFICATE OF NEED:

   Do you have an approved **but not completed,**certificate of need (CON) ? ◯ YES ◉ NO

   If yes, please specify:

| Name of Service or Activity Requiring the CON | # of Beds (if applicable) | Date of Approval |
|---|---|---|
| | 0 | |
| | 0 | |
| | 0 | |

2. Does your hospital own or operate Tennessee physician primary care clinics? ◯ YES ◉ NO If yes, how many? 0
   How many physicians practice in these clinics? 0

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ◯ YES ◉ NO If yes, how many? 0
   How many physicians practice in these clinics? 0

4. Does your hospital own or operate a blood bank? ◯ YES ◉ NO
   If yes, please indicate:

   A. Distributes blood within the hospital ◉ YES ◉ NO
   B. Collects blood within the hospital ◉ YES ◉ NO
   C. Distributes blood outside the hospital ◉ YES ◉ NO
   D. Collects blood from outside the hospital ◉ YES ◉ NO

5. Does your hospital own or operate an ambulance service? ◯ YES ◉ NO
   If yes, please specify the counties where services are located.

   Please specify the type of service and ownership relationship:

   A. Land Transport ◯ YES ◉ NO If yes, ◉ own; ◉ operate; ◉ own and operate; ◉ own in joint venture
   B. Helicopter ◯ YES ◉ NO If yes, ◉ own; ◉ operate; ◉ own and operate; ◉ own in joint venture
   C. Special Neonatal Helicopter ◯ YES ◉ NO If yes, ◉ own; ◉ operate; ◉ own and operate; ◉ own in joint venture
   D. Special Neonatal Land Transport ◯ YES ◉ NO If yes, ◉ own; ◉ operate; ◉ own and operate; ◉ own in joint venture

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Clinic | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Center | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Center | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Center | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Center | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Hospice | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Facility | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

13. Does your hospital own or operate a home for the aged located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Home | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

14. Does your hospital own or operate an urgent care center? ◯ YES ◉ NO
If yes, please complete the following.

| Name of Center | County | City | | | | |
|---|---|---|---|---|---|---|
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |
| | | | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture |

15. Does your hospital own or operate a home health agency? ◯ YES ◉ NO
If yes, please complete the following.

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◉ own ◉ operate ◉ own and operate ◉ own in joint venture

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
◉ own ◉ operate ◉ own and operate ◉ own in joint venture

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ◯ YES ◉ NO
If yes, please complete the following.

_____ _____ _____ ◉ own ◉ operate ◉ own and operate ◉ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ◉ own ◉ operate ◉ own and operate ◉ own in joint venture
Name of Home County City

Number of Beds - Total 0 = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (excluding swing beds)? ◯ YES ◉ NO If yes, please complete the following.

_____ _____ _____
Name of SNF Number of Licensed Beds Number of Staffed Beds

_____ _____
Number of Admissions Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ◯ YES ◉ NO
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |
| 2 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |
| 3 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |
| 4 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |
| 5 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |
| 6 | _____ | ◉ contract | ◉ own | ◉ operate | ◉ own and operate | ◉ own in joint venture | _____ # of visits |

B. List counties served (where you take the service):
***List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | _____ | _____ | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | _____ | _____ | _____ |
| 6 | _____ | _____ | _____ | _____ | _____ | _____ |

19. HOSPITAL-BASED SERVICES (See Explanation):

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| A. Miscellaneous: | | | | | | |
| Lithotripsy | | | | | | |
| Percutaneous | ○ | ◉ | Procedures | 0 | Procedures | 0 |
| Extracorporeal Shock Wave | ○ | ◉ | | | | |
| # fixed units inside hospital 0 | | | Procedures | 0 | Procedures | 0 |
| # fixed units off site 0 | | | | | Procedures | 0 |
| # of mobile units 0 | | | Procedures | 0 | Procedures | 0 |
| # days per week (mobile units) 0 | | | | | | |
| Renal Dialysis | | | | | | |
| # of dedicated stations 0 | | | | | | |
| Hemo Dialysis | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | Treatments | 0 | Treatments | 0 |
| Peritoneal Dialysis | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | Treatments | 0 | Treatments | 0 |
| B. Oncology/Therapies: | | | | | | |
| Chemotherapy | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Encounters | 0 |
| Hyperthermia | ○ | ◉ | Treatments | 0 | Treatments | 0 |
| Radiation Therapy-Megavoltage | ○ | ◉ | | | | |
| # fixed units inside hospital 0 | | | Patients | 0 | Patients | 0 |
| | | | Treatments | 0 | Treatments | 0 |
| # fixed units off site 0 | | | | | | |

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| C. Radiology: | | | | | | |
| Computerized Tomographic Scanners CT/CAT | ◉ | ○ | Patients | 314 | Visits | 2,066 |
| # fixed units inside hospital 1 | | | Procedures | 314 | Procedures | 2,066 |
| # fixed units off site 0 | | | | | Procedures | 0 |
| # of mobile units 0 | | | Procedures | 0 | Procedures | 0 |
| # days per week (mobile units) 0 | | | | | | |
| Ultrafast CT | ○ | ◉ | Patients | 0 | Visits | 0 |
| # fixed units inside hospital 0 | | | Procedures | 0 | Procedures | 0 |
| # fixed units off site 0 | | | | | Procedures | 0 |
| # of mobile units 0 | | | Procedures | 0 | Procedures | 0 |
| # days per week (mobile units) 0 | | | | | | |
| Magnetic Resonance Imaging | ◉ | ◉ | | | | |
| # fixed units inside hospital 0 | | | Procedures | 0 | Procedures | 0 |
| # fixed units off site 0 | | | | | Procedures | 0 |
| # of mobile units 1 | | | Procedures | 15 | Procedures | 235 |
| # days per week (mobile units) 1 | | | | | | |
| Nuclear Medicine | ◉ | ○ | Procedures | 29 | Procedures | 165 |
| Radium Therapy | ○ | ◉ | Procedures | 0 | Procedures | 0 |
| Isotope Therapy | ○ | ◉ | Procedures | 0 | Procedures | 0 |
| Positron Emission Tomography | ○ | ◉ | | | | |
| # fixed units inside hospital 0 | | | Procedures | 0 | Procedures | 0 |
| # fixed units off site 0 | | | | | Procedures | 0 |
| # of mobile units 0 | | | Procedures | 0 | Procedures | 0 |
| # days per week (mobile units) 0 | | | | | | |
| Mammography | ◉ | ○ | Procedures | 1 | Procedures | 339 |
| # of ACR accredited units 1 | | | | | | |
| # other fixed units inside hospital 0 | | | | | | |
| # other fixed units off site 0 | | | | | | |
| # of mobile units 0 | | | | | | |
| # days per week (mobile units) 0 | | | | | | |
| Bone Densitometry | ○ | ◉ | Procedures | 0 | Procedures | 0 |
| # of units 0 | | | | | | |

Note: Pediatric patients should be defined as patients 14 years old and younger.

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | In Cath Lab Setting Unit of Measure | Number | Outside Cath Lab Setting Unit of Measure | Number |
|---|---|---|---|---|---|---|
| D. Cardiac: | | | | | | |
| Cardiac Catheterization | | | | | | |
| Date Initiated _____ | | | | | | |
| # labs 0 | | | | | | |
| Intra-Cardiac or Coronary Artery | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| Percutaneous Transluminal Coronary Angioplasty | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| Stents | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| All Other Heart Procedures | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| All Other Non-Cardiac Procedures | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| Thrombolytic Therapy | ○ | ◉ | Adult Procedures | 0 | Adult Procedures | 0 |
| | | | Pediatric Procedures | 0 | Pediatric Procedures | 0 |
| | | | To Inpatients | | To Outpatients | |
| Open Heart Surgery | ○ | ◉ | Adult Operations | 0 | | |
| # dedicated O.R.'s 0 | | | Pediatric Operations | 0 | | |
| E. Surgery: | | | | | | |
| Inpatient | ○ | ◉ | Encounters | 0 | | |
| # operating rooms 0 | | | Procedures | 0 | | |
| Outpatient (one day) | ◉ | ○ | | | Encounters | 28 |
| # dedicated O.R.'s 1 | | | | | Procedures | 0 |
| F. Rehabilitation: | | | | | | |
| Cardiac | ○ | ◉ | Patients | 0 | Patients | 0 |

SCHEDULE D - SERVICES (continued)* State ID 70223

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| F. Rehabilitation (continued): | | | | | | |
| Chemical Dependency | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Nutritional Counseling | ◉ | ○ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Pulmonary | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| G. Physical Rehabilitation: | | | | | | |
| Occupational Therapy | ◉ | ○ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Orthotic Services | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Physical Therapy | ◉ | ○ | Patients | 856 | Patients | 1,041 |
| | | | | | Episodes of Care | 0 |
| Prosthetic Services | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Speech/Language Therapy | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |
| Therapeutic Recreational Service | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | | | Episodes of Care | 0 |

Do you have a dedicated inpatient physical rehabilitation unit? ○ YES ◉ NO

If yes, please complete the following. Number of assigned beds 0 Number of admissions 0 Number of patient days 0

Do you have a dedicated outpatient physical rehabilitation unit? ○ YES ◉ NO

| | | | | | | |
|---|---|---|---|---|---|---|
| H. Pain Management: | ○ | ◉ | Patients | 0 | Patients | 0 |

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| I. Obstetrics/Newborn: | | | | | | |
| Obstetrics Level of Care | | | | | | |
| Level I | ○ | ◉ | | | | |
| Level II | ○ | ◉ | | | | |
| Level III | ○ | ◉ | | | | |
| Cesarean Section Deliveries | ○ | ◉ | Deliveries | 0 | | |
| Non C-Section Deliveries | ○ | ◉ | Deliveries | 0 | | |
| Birthing Rooms | ○ | ◉ | Deliveries | 0 | | |
| # rooms 0 | | | | | | |
| # LDRP beds 0 | | | | | | |
| # LDR beds 0 | | | | | | |
| Labor Rooms | ○ | ◉ | | | | |
| # rooms 0 | | | | | | |
| Postpartum Services | ○ | ◉ | Patients | 0 | Visits | 0 |
| # beds 0 | | | | | | |
| Newborn Nursery | ○ | ◉ | Infants Discharged | 0 | | |
| # bassinets 0 | | | Patient Days | 0 | | |
| Premature Nursery | ○ | ◉ | Infants Discharged | 0 | | |
| # bassinets 0 | | | Patient Days | 0 | | |
| Isolation Nursery | ○ | ◉ | Patient Days | 0 | | |
| # bassinets 0 | | | | | | |

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| J. Transplants: | | | | | | |
| Organs | | | | | | |
| Total Donors | | | Donors | 0 | | |
| Total Harvested | ○ | ◉ | Donations | 0 | | |
| Transplants | ○ | ◉ | Transplants | 0 | | |
| Organ Bank | ○ | ◉ | Organs | 0 | | |
| Type of Organ: | | | | | | |
| Heart | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Liver | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Kidneys | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Pancreas | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Intestine | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Any Other _____ | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | | |
| Tissues | | | | | | |
| Total Donors | | | Donors | 0 | | |
| Total Harvested | ○ | ◉ | Donations | 0 | | |
| Transplants | ○ | ◉ | Transplants | 0 | | |
| Tissue Bank | ○ | ◉ | Tissues | 0 | | |
| Type of Tissue: | | | | | | |
| Eye | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Bone | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Bone Marrow | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Connective | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Cardiovascular | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Stem Cell | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |
| Other _____ | ○ | ◉ | # Harvested | 0 | | |
| | | | # Transplanted | 0 | # Transplanted | 0 |

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | Number | To Outpatients Unit of Measure | Number |
|---|---|---|---|---|---|---|
| K. Other: | | | | | | |
| Hyperbaric Oxygen Therapy | ○ | ◉ | Patients | 0 | | |
| Gamma Knife | ○ | ◉ | Patients | 0 | Patients | 0 |
| Cyberknife | ○ | ◉ | Patients | 0 | Patients | 0 |
| L. Intensive/Intermediate: | | | | | | |
| Burn Care Unit # beds 0 | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | Patient Days | 0 | | |
| Cardiac Care Unit # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Medical Intensive Care Unit # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Mixed Intensive Care Unit # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Neonatal Level of Care (Indicate highest level of care.) | | | | | | |
| Level I # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Level II A # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Level II B # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Level III A # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Level III B # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Level III C # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Pediatric Care Unit # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Stepdown ICU # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Stepdown CCU # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |
| Surgical Intensive Care Unit # beds 0 | ○ | ◉ | Patients | 0 | | |
| | | | Patient Days | 0 | | |

| Utilization of Selected Services | Is This Service Provided In Your Hospital? YES | NO | To Inpatients Unit of Measure | To Inpatients Number | To Outpatients Unit of Measure | To Outpatients Number |
|---|---|---|---|---|---|---|
| L. Intensive/Intermediate (continued): | | | | | | |
| Other, specify _____ | ○ | ◉ | Patients | 0 | | |
| Number of beds 0 | | | Patient Days | 0 | | |
| Other, specify _____ | ○ | ◉ | Patients | 0 | | |
| Number of beds 0 | | | Patient Days | 0 | | |
| M. Psychiatric Partial Hospitalization | ○ | ◉ | Patients | 0 | | |
| N. Psychiatric Intensive Outpatient Care | ○ | ◉ | | | Patients | 0 |
| O. Electroconvulsive Treatment | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | Treatments | 0 | Treatments | 0 |
| P. Other Convulsive Treatment | ○ | ◉ | Patients | 0 | Patients | 0 |
| | | | Treatments | 0 | Treatments | 0 |
| Q. Negative Pressure Ventilated Room | ◉ | ○ | | | | |
| If yes, number of beds 2 | | | | | | |

R. 23 Hour Observation ◉ YES ○ NO Outpatients 724

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? 29
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during this reporting period? 0
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? 0

SCHEDULE E - FINANCIAL DATA*

State ID 70223

Dates covered from 10/01/2012 to 09/30/2013 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

| | Gross Patient Charges | minus | Adjustments To Charges | equals | Net Patient Revenue |
|---|---|---|---|---|---|
| 1. Government | | | | | |
| a) Medicare Inpatient - Total (include managed care) | $7,227,100 | - | $4,426,764 | = | $2,800,336 |
| 1) Medicare Managed Care - Inpatient | $0 | - | $0 | = | $0 |
| b) Medicare Outpatient - Total (include managed care) | $11,328,972 | - | $8,917,296 | = | $2,411,676 |
| 1) Medicare Managed Care - Outpatient | $0 | - | $0 | = | $0 |
| c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.) | $1,043,035 | - | $805,808 | = | $237,227 |
| d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.) | $4,820,724 | - | $4,599,676 | = | $221,048 |
| e) Other | $0 | - | $0 | = | $0 |
| f) Total Government Sources | $24,419,831 | - | $18,749,544 | = | $5,670,287 |
| 2. Cover Tennessee * see instructions | | | | | |
| a) Cover TN | $0 | - | $0 | = | $0 |
| b) Cover Kids | $0 | - | $0 | = | $0 |
| c) Access Tennessee | $0 | - | $0 | = | $0 |
| d) Total Cover Tennessee | $0 | - | $0 | = | $0 |
| 3. Nongovernment | | | | | |
| a) Self-Pay | $4,335,099 | - | $897,997 | = | $3,437,102 |
| b) Blue Cross Blue Shield | $3,007,116 | - | $1,831,032 | = | $1,176,084 |
| c) Commercial Insurers (excludes Workers Comp) | $5,848,602 | - | $3,143,429 | = | $2,705,173 |
| d) Workers Compensation | $227,939 | - | $93,273 | = | $134,666 |
| e) Other | $442 | - | $17 | = | $425 |
| f) Total Nongovernment Sources | $13,419,198 | - | $5,965,748 | = | $7,453,450 |
| 4. Totals | | | | | |
| a) Total Inpatient (excludes Newborn) | $11,022,751 | | | | |
| b) Newborns | $0 | | | | |
| c) Total Inpatient (includes Newborn) (A4a + A4b) | $11,022,751 | - | $6,360,746 | = | $4,662,005 |
| d) Total Outpatient | $26,816,278 | - | $18,354,546 | = | $8,461,732 |
| e) Grand Total (A1f + A2d + A3f) | $37,839,029 | - | $24,715,292 | = | $13,123,737 |
| 5. Bad Debt | | | | | |
| a) Medicare Enrollees | | | $214,569 | | |
| b) Other Government | | | $0 | | |
| c) Cover Tennessee | | | $0 | | |
| d) Blue Cross and Commercially Insured Patients | | | $339,868 | | |
| e) All Other | | | $3,888,143 | | |
| f) Total Bad Debt | | | $4,442,580 | | |
| 6. Nongovernment and Cover Tennessee Adjustments to Charges | | | | | |
| a) Nongovernment Contractual | | | $5,520,261 | | |
| b) Cover Tennessee Contractual | | | $0 | | |
| c) Charity Care - Inpatient | | | $0 | | |
| d) Charity Care - Outpatient | | | $103,055 | | |
| e) Other Adjustments, specify types Bankr, time limit, disc, community benefit | | | $342,433 | | |
| f) Total Nongovernment Adjustments | | | $5,965,749 | | |

Amount of discounts provided to uninsured patients $0

$103,055 Total Charity (A6c + A6d)

$4,545,635 Total Charity plus Bad Debt (A5f + A6c + A6d)

A. CHARGES (continued)

7. Other Operating Revenue

| | |
|---|---|
| a) Tax appropriations | $0 |
| b) State and Local government contributions: | |
| 1) Amount designated to offset indigent care | $0 |
| 2) Essential Access Hospital (EAH) payments | $0 |
| 3) Critical Access Hospital (CAH) payments | $281,381 |
| 4) Amount used for other | $0 |
| 5) Total | $281,381 |
| c) Other contributions: | |
| 1) Amount designated to offset indigent care | $0 |
| 2) Amount used for other | $0 |
| 3) Total | $0 |
| d) Other (include cafeteria, gift shop, etc.) | $125,179 |
| e) Total other operating revenue (A7a + A7b5 + A7c3 + A7d) | $406,560 |

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

| | |
|---|---|
| a) Contributions | $4,910 |
| b) Grants | $73,530 |
| c) Interest Income | $524 |
| d) Other | $0 |
| e) Total nonoperating revenue (add A8a through A8d) | $78,964 |
| f) TOTAL REVENUE (Net A4e + A7e + A8e) | $13,609,261 |

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

| | |
|---|---|
| a) Physicians and dentists (include only salaries) | $0 |
| b) Medical and dental residents (include medical and dental interns) | $0 |
| c) Trainees (medical technology, x-ray therapy, administrative, and so forth) | $0 |
| d) Registered and licensed practical nurses | $1,419,438 |
| e) All other personnel | $2,611,524 |
| f) Total payroll expenses (add B1a through B1e) | $4,030,962 |

2. Nonpayroll Expenses

| | |
|---|---|
| a) Employee benefits (social security, group insurance, retirement benefits) | $878,489 |
| b) Professional fees (medical, dental, legal, auditing, consultant and so forth) | $1,191,088 |
| c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies) | $0 |
| d) Depreciation expense | $330,160 |
| e) Interest expense | $209,400 |
| f) Energy expense | $239,205 |
| g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth) | $6,683,803 |
| h) Total nonpayroll expenses (add B2a through B2g) | $9,532,145 |
| i) TOTAL EXPENSES (add B1f + B2h) | $13,563,107 |

3. Are system overhead/management fees included in your expenses? (●) YES ( ) NO

If yes, specify amount $0

C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year.
   What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $1,230,422
   Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.
2. What were your net receivables on the last day of your reporting period? $529,479

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment) $4,642,831
2. LESS: Deduction for accumulated depreciation $3,872,795
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) $770,036

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).
What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).
What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? $2,000,458

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? $1,316,080

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? $3,072,438
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? $0

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? $0

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? -$2,388,060
Note: Total Assets should equal Liabilities plus Capital Account (i.e. item F.=G.+H.1.+I.+J.).

K. 1. Federal Income Tax: $0

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility $0
   b) Taxes on all Other Property $0

3. Other Local, State, or Federal Taxes: (exclude sales tax) $0

L. Does your hospital bill include charges incurred for the following professional services?

Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ◉ YES ○ NO Other - Specify

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

| MCO | NUMBER OF ADMISSIONS | NUMBER OF PATIENT DAYS | GROSS REVENUE | NET REVENUE |
|---|---|---|---|---|
| United Health Care Community Plan | 18 | 60 | $235,581 | $0 |
| Amerigroup | 0 | 0 | $0 | $0 |
| Blue Care | 21 | 99 | $293,215 | $0 |
| TennCare Select | 3 | 14 | $44,117 | $0 |
| TennCare, MCO (Not Specified) | 0 | 0 | $0 | $0 |
| Total MCO | 42 | 173 | $572,913 | $0 |

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

| MCO | NUMBER OF PATIENTS | NUMBER OF VISITS | GROSS REVENUE | NET REVENUE |
|---|---|---|---|---|
| United Health Care Community Plan | 817 | 817 | $1,283,947 | $0 |
| Amerigroup | 0 | 0 | $0 | $0 |
| Blue Care | 1,287 | 1,287 | $1,849,899 | $0 |
| TennCare Select | 16 | 16 | $23,034 | $0 |
| TennCare, MCO (Not Specified) | 0 | 0 | $0 | $0 |
| Total MCO | 2,120 | 2,120 | $3,156,880 | $0 |

SCHEDULE F - BEDS AND BASSINETS* State ID 70223

1. PLEASE GIVE THE NUMBER OF:

   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 25
   B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. 25
   C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIO 0
   D. Licensed Beds that were not staffed at any time during the reporting period. 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ◯ YES ◉ NO
   If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

   Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0 Bed change (+ or -) 0
   Date: Date: Date: Date:

3 SWING BEDS:

   A. Does your facility utilize swing beds? ◉ YES ◯ NO If yes, number of Acute Care beds designated as Swing Beds. 8

   B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

| INTERMEDIATE CARE | ADMISSIONS | PATIENT DAYS |
|---|---|---|
| Private Pay | 0 | 0 |
| Other | 61 | 544 |
| Total | 61 | 544 |

| SKILLED CARE | ADMISSIONS | PATIENT DAYS |
|---|---|---|
| Commercial | 0 | 0 |
| Blue Cross | 0 | 0 |
| Medicare | 0 | 0 |
| Private Pay | 0 | 0 |
| Other | 0 | 0 |
| Total | 0 | 0 |

4. A. Number of Beds Set Up and Staffed on a typical day

| SERVICE | BEDS |
|---|---|
| Medical | 17 |
| Surgical | 0 |
| Medical/Surgical | 0 |
| Obstetrics | 0 |
| Gynecological | 0 |
| OB/GYN | 0 |
| Pediatric | 0 |
| Eye | 0 |
| Neonatal Care | 0 |
| Intensive Care (excluding Neonatal) | 0 |
| Orthopedic | 0 |
| Urology | 0 |
| Rehabilitation | 0 |
| Chronic/Extended Care | 0 |
| Pulmonary | 0 |
| Psychiatric | 0 |
| Psychiatric specifically for Children and Youth under age 18 | 0 |
| Psychiatric specifically for Geriatric Patients | 0 |
| Chemical Dependency | 0 |
| Chemical Dependency specifically for Children and Youth under age 18 | 0 |
| Chemical Dependency specifically for Geriatric Patients | 0 |
| Swing Beds (for long term skilled or intermediate care) | 8 |
| Other, specify | 0 |
| Unassigned | 0 |
| TOTAL | 25 |

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 13

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ◉ YES ○ NO If yes, number of beds 25

B. Do you have beds assigned to dedicated 23-hour observation unit? ○ YES ◉ NO If yes, number of beds 0

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ○ YES ◉ NO
If yes, number of beds 0

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days ○
   or Discharges and Discharge Patient Days ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

| MAJOR DIAGNOSTIC CATEGORIES | ADMISSIONS OR DISCHARGES | INPATIENT DAYS OR DISCHARGE PATIENT DAYS |
|---|---|---|
| 01 Nervous System | 33 | 165 |
| 02 Eye | 1 | 1 |
| 03 Ear, Nose, Mouth and Throat | 18 | 62 |
| 04 Respiratory System | 321 | 1,602 |
| 05 Circulatory System | 79 | 250 |
| 06 Digestive System | 85 | 305 |
| 07 Hepatobiliary System & Pancreas | 25 | 93 |
| 08 Musculoskeletal Sys. & Connective Tissue | 35 | 202 |
| 09 Skin, Subcutaneous Tissue & Breast | 47 | 232 |
| 10 Endocrine, Nutritional & Metabolic | 39 | 161 |
| 11 Kidney & Urinary Tract | 99 | 397 |
| 12 Male Reproductive System | 4 | 10 |
| 13 Female Reproductive System | 1 | 2 |
| 14 Pregnancy, Childbirth & the Puerperium | 0 | 0 |
| 15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period | 0 | 0 |
| 16 Blood and Blood Forming Organs and Immunological Disorders | 6 | 23 |
| 17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms | 0 | 0 |
| 18 Infectious & Parasitic Diseases | 17 | 77 |
| 19 Mental Diseases & Disorders | 10 | 31 |
| 20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders | 1 | 15 |
| 21 Injuries, Poisoning, & Toxic Effects of Drugs | 4 | 15 |
| 22 Burns | 1 | 4 |
| 23 Factors Influencing Health Status and Other Contacts with Health Services | 70 | 426 |
| 24 Multiple Significant Trauma | 0 | 0 |
| 25 Human Immunodeficiency Virus Infections | 0 | 0 |
| 26 Other DRGs Associated with All MDCs | 0 | 0 |
| TOTAL | 896 | 4,073 |

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

**Patients should be categorized according to primary payer and counted only once.**

Please indicate whether you are reporting Admissions and Inpatient Days ◯ or Discharges and Discharge Patient Days ◉

| | ADMISSIONS OR DISCHARGES | INPATIENT DAYS OR DISCHARGE PATIENT DAYS | OUTPATIENT VISITS* |
|---|---|---|---|
| a) Self Pay | 39 | 159 | 2,814 |
| b) Blue Cross/Blue Shield | 38 | 154 | 1,591 |
| c) Champus/TRICARE | 0 | 0 | 0 |
| d) Commercial Insurance (excludes Workers Comp) | 151 | 653 | 2,628 |
| e) Cover TN | 0 | 0 | 0 |
| f) Cover Kids | 0 | 0 | 0 |
| g) Access TN | 0 | 0 | 0 |
| h) Medicaid/Tenncare | 71 | 306 | 3,164 |
| i) Medicare - Total | 597 | 2,801 | 7,323 |
| Medicare Managed Care | 0 | 0 | 0 |
| j) Workers Compensation | 0 | 0 | 0 |
| k) Other | 0 | 0 | 361 |
| l) Total | 896 | 4,073 | 17,881 |

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days ◯ or Discharges and Discharge Patient Days ◉

| Age | ADMISSIONS OR DISCHARGES | INPATIENT DAYS OR DISCHARGE PATIENT DAYS | OUTPATIENT VISITS* |
|---|---|---|---|
| Under 15 years | 0 | 0 | 0 |
| 15-17 years | 0 | 0 | 0 |
| 18-64 years | 0 | 0 | 0 |
| 65-74 years | 0 | 0 | 0 |
| 75-84 years | 0 | 0 | 0 |
| 85 years & older | 0 | 0 | 0 |
| GRAND TOTAL | 0 | 0 | 0 |

* Should include emergency department visits and hospital outpatient visits

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

| County # | Tennessee County of Residence | Number of Admissions or Discharges | Number of Inpatient Days or Discharge Patient Days |
|---|---|---|---|
| 01 | Anderson | 0 | 0 |
| 02 | Bedford | 0 | 0 |
| 03 | Benton | 0 | 0 |
| 04 | Bledsoe | 0 | 0 |
| 05 | Blount | 0 | 0 |
| 06 | Bradley | 0 | 0 |
| 07 | Campbell | 0 | 0 |
| 08 | Cannon | 0 | 0 |
| 09 | Carroll | 0 | 0 |
| 10 | Carter | 0 | 0 |
| 11 | Cheatham | 0 | 0 |
| 12 | Chester | 0 | 0 |
| 13 | Claiborne | 0 | 0 |
| 14 | Clay | 0 | 0 |
| 15 | Cocke | 0 | 0 |
| 16 | Coffee | 0 | 0 |
| 17 | Crockett | 0 | 0 |
| 18 | Cumberland | 0 | 0 |
| 19 | Davidson | 0 | 0 |
| 20 | Decatur | 0 | 0 |
| 21 | DeKalb | 0 | 0 |
| 22 | Dickson | 0 | 0 |
| 23 | Dyer | 0 | 0 |
| 24 | Fayette | 0 | 0 |
| 25 | Fentress | 0 | 0 |
| 26 | Franklin | 0 | 0 |
| 27 | Gibson | 0 | 0 |
| 28 | Giles | 0 | 0 |

5. PATIENT ORIGIN (continued)

| County # | Tennessee County of Residence | Number of Admissions or Discharges | Number of Inpatient Days or Discharge Patient Days |
|---|---|---|---|
| 29 | Grainger | 0 | 0 |
| 30 | Greene | 0 | 0 |
| 31 | Grundy | 0 | 0 |
| 32 | Hamblen | 0 | 0 |
| 33 | Hamilton | 0 | 0 |
| 34 | Hancock | 0 | 0 |
| 35 | Hardeman | 0 | 0 |
| 36 | Hardin | 0 | 0 |
| 37 | Hawkins | 0 | 0 |
| 38 | Haywood | 0 | 0 |
| 39 | Henderson | 0 | 0 |
| 40 | Henry | 0 | 0 |
| 41 | Hickman | 0 | 0 |
| 42 | Houston | 0 | 0 |
| 43 | Humphreys | 0 | 0 |
| 44 | Jackson | 0 | 0 |
| 45 | Jefferson | 0 | 0 |
| 46 | Johnson | 0 | 0 |
| 47 | Knox | 0 | 0 |
| 48 | Lake | 0 | 0 |
| 49 | Lauderdale | 0 | 0 |
| 50 | Lawrence | 0 | 0 |
| 51 | Lewis | 0 | 0 |
| 52 | Lincoln | 0 | 0 |
| 53 | Loudon | 0 | 0 |
| 54 | McMinn | 0 | 0 |
| 55 | McNairy | 0 | 0 |
| 56 | Macon | 0 | 0 |
| 57 | Madison | 0 | 0 |
| 58 | Marion | 0 | 0 |
| 59 | Marshall | 0 | 0 |
| 60 | Maury | 0 | 0 |
| 61 | Meigs | 0 | 0 |
| 62 | Monroe | 0 | 0 |

5. PATIENT ORIGIN (continued)

| County # | Tennessee County of Residence | Number of Admissions or Discharges | Number of Inpatient Days or Discharge Patient Days |
|---|---|---|---|
| 63 | Montgomery | 0 | 0 |
| 64 | Moore | 0 | 0 |
| 65 | Morgan | 0 | 0 |
| 66 | Obion | 0 | 0 |
| 67 | Overton | 0 | 0 |
| 68 | Perry | 0 | 0 |
| 69 | Pickett | 0 | 0 |
| 70 | Polk | 0 | 0 |
| 71 | Putnam | 0 | 0 |
| 72 | Rhea | 0 | 0 |
| 73 | Roane | 0 | 0 |
| 74 | Robertson | 0 | 0 |
| 75 | Rutherford | 0 | 0 |
| 76 | Scott | 0 | 0 |
| 77 | Sequatchie | 0 | 0 |
| 78 | Sevier | 0 | 0 |
| 79 | Shelby | 0 | 0 |
| 80 | Smith | 0 | 0 |
| 81 | Stewart | 0 | 0 |
| 82 | Sullivan | 0 | 0 |
| 83 | Sumner | 0 | 0 |
| 84 | Tipton | 0 | 0 |
| 85 | Trousdale | 0 | 0 |
| 86 | Unicoi | 0 | 0 |
| 87 | Union | 0 | 0 |
| 88 | Van Buren | 0 | 0 |
| 89 | Warren | 0 | 0 |
| 90 | Washington | 0 | 0 |
| 91 | Wayne | 0 | 0 |
| 92 | Weakley | 0 | 0 |
| 93 | White | 0 | 0 |
| 94 | Williamson | 0 | 0 |
| 95 | Wilson | 0 | 0 |
| 96 | TN County Unknown | 0 | 0 |
| | ***Tennessee Total*** | 0 | 0 |

5. PATIENT ORIGIN (continued)

| State & County Residence | Number of Admissions or Discharges | Number of Inpatient Days or Discharge Patient Days |
|---|---|---|
| ALABAMA COUNTIES: (Specify) | | |
| 1) | 0 | 0 |
| 2) | 0 | 0 |
| Other Alabama Counties | 0 | 0 |
| *Alabama Total* | 0 | 0 |
| GEORGIA COUNTIES: (Specify) | | |
| 1) | 0 | 0 |
| 2) | 0 | 0 |
| Other Georgia Counties | 0 | 0 |
| *Georgia Total* | 0 | 0 |
| MISSISSIPPI COUNTIES: (Specify) | | |
| 1) | 0 | 0 |
| 2) | 0 | 0 |
| Other Mississippi Counties | 0 | 0 |
| *Mississippi Total* | 0 | 0 |
| ARKANSAS COUNTIES: (Specify) | | |
| 1) | 0 | 0 |
| 2) | 0 | 0 |
| Other Arkansas Counties | 0 | 0 |
| *Arkansas Total* | 0 | 0 |
| MISSOURI COUNTIES: (Specify) | | |
| 1) | 0 | 0 |
| 2) | 0 | 0 |
| Other Missouri Counties | 0 | 0 |
| *Missouri Total* | 0 | 0 |

5. PATIENT ORIGIN (continued)

| State & County Residence | | Number of Admissions or Discharges | Number of Inpatient Days or Discharge Patient Days |
|---|---|---|---|
| KENTUCKY COUNTIES: (Specify) | | | |
| 1) | | 0 | 0 |
| 2) | | 0 | 0 |
| Other Kentucky Counties | | 0 | 0 |
| *Kentucky Total* | | 0 | 0 |
| VIRGINIA COUNTIES: (Specify) | | | |
| 1) | | 0 | 0 |
| 2) | | 0 | 0 |
| Other Virginia Counties | | 0 | 0 |
| *Virginia Total* | | 0 | 0 |
| NORTH CAROLINA COUNTIES: (Specify) | | | |
| 1) | | 0 | 0 |
| 2) | | 0 | 0 |
| Other North Carolina Counties | | 0 | 0 |
| *North Carolina Total* | | 0 | 0 |
| OTHER STATES: (Specify) | | | |
| 1) | | 0 | 0 |
| 2) | | 0 | 0 |
| All Other States and Countries | | 0 | 0 |
| | | | |
| RESIDENCE UNKNOWN: | | 0 | 0 |
| ***GRAND TOTAL*** | | 0 | 0 |

6. Delivery Status:

   A. Number of Infants Born Alive 0

   B. Number of Deaths Among Infants Born Alive 0

   C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) 0

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit? ◯ YES ◉ NO If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? ◯ YES ◉ NO

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days. ◉

| | Inpatient | | | Partial Care or Day Hospital | Outpatient |
|---|---|---|---|---|---|
| AGE GROUPS | Number of Patients on September 30 | Number of Admissions or Discharges | Number of Inpatient or Discharge Patient Days | Number of Sessions | Number of Visits |
| Children and/or Adolescents Ages 0 - 17 | 0 | 0 | 0 | 0 | 0 |
| Adults Ages 18 - 64 | 0 | 0 | 0 | 0 | 0 |
| Elderly Ages 65 and older | 0 | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 0 | 0 | 0 |

4. Is the psychiatric service managed under a management contract different from the hospital itself? ◉ YES ◉ NO
   If yes, please specilfy name of organization that manages the unit.

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◉ NO

6. Does your hospital use:

| | | | If Yes, Number of Patients Secluded or Restrained | | Number of Times Seclusion or Restraint was Initiated | |
|---|---|---|---|---|---|---|
| | | | Age 0-17 | Age 18+ | Age 0-17 | Age 18+ |
| A. Seclusion | ◉ YES | ◉ NO | 0 | 0 | 0 | 0 |
| B. Mechanical Restraints | ◉ YES | ◉ NO | 0 | 0 | 0 | 0 |
| C. Physical Holding Restraints | ◉ YES | ◉ NO | 0 | 0 | 0 | 0 |
| D. Chemical Restraints | ◉ YES | ◉ NO | 0 | 0 | 0 | 0 |

7. FINANCIAL DATA - PSYCHIATRIC

| | INPATIENT CHARGES | | OUTPATIENT CHARGES | | TOTAL CHARGES | | ADJUSTMENTS TO CHARGES | | NET PATIENT REVENUE |
|---|---|---|---|---|---|---|---|---|---|
| | | plus | | equals | | minus | | equals | |
| A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER: | | | | | | | | | |
| 1. Self Pay | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 2. Blue Cross/Blue Shield | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 3. Champus/TRICARE | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 4. Commercial Insurance (excludes Workers Comp) | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 5. Cover TN | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 6. Cover Kids | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 7. Access TN | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 8. Medicaid/Tenncare | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 9. Medicare - Total | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| Medicare Managed Care | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 10. Workers Compensation | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 11. Other | $0 | + | $0 | = | $0 | - | $0 | = | $0 |

| B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE | |
|---|---|
| 1. Bad Debt | $0 |
| 2. Charity Care | $0 |
| 3. Contractual Adjustments | $0 |
| 4. Total | $0 |
| 5. Amount of discounts provided to uninsured patients | $0 |

8. A. SERVICE CHARGES

| | INPATIENT CHARGES | OUTPATIENT CHARGES |
|---|---|---|
| 1. Routine Treatment | $0 | $0 |
| 2. Ancillary Services | $0 | $0 |
| 3. Other | $0 | $0 |
| 4. Total | $0 | $0 |

B. Do these charges include physicians' fees? ◉ YES ◉ NO

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? ◯ YES ◉ NO If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds 0
   B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days. ◉

| | Inpatient | | | Partial Care or Day Hospital | Outpatient | Residential Care |
|---|---|---|---|---|---|---|
| AGE GROUPS | Number of Patients on September 30 | Number of Admissions or Discharges | Number of Inpatient or Discharge Patient Days | Number of Sessions | Number of Visits | Number of Visits |
| Children and/or Adolescents Ages 0 - 17 | 0 | 0 | 0 | 0 | 0 | 0 |
| Adults Ages 18 - 64 | 0 | 0 | 0 | 0 | 0 | 0 |
| Elderly Ages 65 and older | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 0 | 0 | 0 | 0 |

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ◯ YES ◉ NO
   If yes, please specilfy name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ◯ YES ◉ NO

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

| | INPATIENT CHARGES | plus | OUTPATIENT CHARGES | equals | TOTAL CHARGES | minus | ADJUSTMENTS TO CHARGES | equals | NET PATIENT REVENUE |
|---|---|---|---|---|---|---|---|---|---|
| A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER: | | | | | | | | | |
| 1. Self Pay | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 2. Blue Cross/Blue Shield | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 3. Champus/TRICARE | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 4. Commercial Insurance (excludes Workers Comp) | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 5. Cover TN | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 6. Cover Kids | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 7. Access TN | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 8. Medicaid/Tenncare | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 9. Medicare - Total | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| Medicare Managed Care | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 10. Workers Compensation | $0 | + | $0 | = | $0 | - | $0 | = | $0 |
| 11. Other | $0 | + | $0 | = | $0 | - | $0 | = | $0 |

| B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE | |
|---|---|
| 1. Bad Debt | $0 |
| 2. Charity Care | $0 |
| 3. Contractual Adjustments | $0 |
| 4. Total | $0 |
| 5. Amount of discounts provided to uninsured patients | $0 |

7. A. SERVICE CHARGES

| | INPATIENT CHARGES | OUTPATIENT CHARGES |
|---|---|---|
| 1. Routine Treatment | $0 | $0 |
| 2. Ancillary Services | $0 | $0 |
| 3. Other | $0 | $0 |
| 4. Total | $0 | $0 |

B. Do these charges include physicians' fees? ◉ YES ◉ NO

SCHEDULE I - EMERGENCY DEPARTMENT* State ID 70223

1. What is the direct telephone number into your Emergency Department? (423) 496-8139

2. Is the Emergency Department managed under a management contract different from the hospital itself? (•) YES ( ) NO
   If yes, with whom is the contract held? East Tennessee ER Physicians - Physicians Only

3. Emergency Department:

   Number of visits by payer:

| | | | | | |
|---|---|---|---|---|---|
| A. Self Pay | 1,371 | H. Medicaid/Tenncare | | L. Grand Total | 6,859 |
| B. Blue Cross/Blue Shield | 500 | United Health Care Community Plan | 0 | | |
| C. Champus/TRICARE | 0 | Amerigroup | 0 | | |
| D. Commercial Insurance (excludes Workers Comp) | 783 | Blue Care | 0 | | |
| | | TennCare Select | 0 | | |
| | | TennCare, MCO (Not Specified) | 2,263 | | |
| | | TennCare Total | 2,263 | | |
| E. Cover TN | 0 | I. Medicare - Total | 1,373 | | |
| F. Cover Kids | 0 | Medicare Managed Care | 0 | | |
| G. Access TN | 0 | J. Workers Compensation | 0 | | |
| | | K. Other | 569 | | |

4. Is your Emergency Department staffed 24 hours per day? ( ) YES ( ) NO If no, please give hours covered. 0

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

| | ON HOSPITAL CAMPUS | IN EMERGENCY DEPARTMENT |
|---|---|---|
| A. PHYSICIANS: | | |
| Board certified in Emergency Medicine | 0 | 0 |
| Board eligible in Emergency Medicine | 0 | 0 |
| Declared Speciality of Emergency Medicine | 0 | 0 |
| Board Certified Psychiatrists | 0 | 0 |
| Other Physicians Available to Emergency Department | 2 | 2 |
| B. NURSES: | | |
| Nurse Practitioners | 0 | 0 |
| R.N.'s with formal emergency training and experience | 3 | 2 |
| Other R.N.'s | 2 | 0 |
| L.P.N.'s and other nursing support personnel | 4 | 2 |
| Clerical Staff | 1 | 0 |
| C. OTHER: | | |
| E.M.T. | 0 | 0 |
| E.M.T. advanced | 0 | 0 |

6. SUPPORTIVE SERVICES:

| | YES | NO |
|---|---|---|
| A. COMMUNICATIONS: | | |
| Two-Way radio in ER with Access to: | | |
| Central Emergency Dispatch Center | ◉ | ○ |
| Ambulances | ◉ | ○ |
| Other hospitals | ◉ | ○ |
| B. HELIPORT: | ◉ | ○ |
| C. PHARMACY IN ER: | ○ | ◉ |
| D. BLOOD BANK (check ONLY one): | | |
| Fully stocked | ◉ | |
| Common blood types only | ◉ | |

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center ○ YES ◉ NO

B. Burns ○ YES ◉ NO

If yes, do you have a designation by a government agency as a Burn Center? ○ YES ◉ NO

C. Pediatrics ○ YES ◉ NO

D. Other, specify _____

8. Triage:
   A. Total number of patients who presented in your ER. 6,859
   B. Total number treated in your ER. 6,859
   C. Total number not treated in your ER but referred to physician or clinic for treatment. 0

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES* State ID 70223

| | Full-Time Equivalent** | Full-Time Equivalent Budgeted Vacancies | Use Contract Staff in this Employee Category*** |
|---|---|---|---|
| 1. Administration: | | | |
| A. Administrators & Assistants | 1.0 | 0.0 | ☐ |
| B. Director, Health Services Research & Assistants | 0.0 | 0.0 | ☐ |
| C. Marketing & Planning Officer(s) & Assistants | 0.0 | 0.0 | ☐ |
| D. Financial and Accounting Officer(s) & Assistants | 1.0 | 0.0 | ☐ |
| 2. Physician and Dental Services: | | | |
| A. Physicians | 0.0 | 0.0 | ☐ |
| B. Medical residents | 0.0 | 0.0 | ☐ |
| C. Dentists | 0.0 | 0.0 | ☐ |
| D. Dental residents | 0.0 | 0.0 | ☐ |
| 3. Nursing Services: | | | |
| A. RNs - Administrative | 1.0 | 0.0 | ☐ |
| B. RNs - Patient care/clinical | 25.5 | 0.0 | ☐ |
| C. LPNs | 14.5 | 0.0 | ☐ |
| D. Ancillary nursing personnel | 0.0 | 0.0 | ☐ |
| 4. Certified Nurse Midwives | 0.0 | 0.0 | ☐ |
| 5. Nurse Anesthetists | 0.0 | 0.0 | ☐ |
| 6. Physicians assistants | 0.0 | 0.0 | ☐ |
| 7. Nurse practitioners | 0.0 | 0.0 | ☐ |
| 8. Medical record service: | | | |
| A. Medical record administrators | 1.0 | 0.0 | ☐ |
| B. Medical record technicians (certified or accredited) | 0.0 | 0.0 | ☐ |
| C. Other Medical record technicians | 3.0 | 0.0 | ☐ |
| 9. Pharmacy: | | | |
| A. Pharmacists, licensed | 2.0 | 0.0 | ☐ |
| B. Pharmacy technicians | 2.0 | 0.0 | ☐ |
| C. Clinical Phar-D | 0.0 | 0.0 | ☐ |
| 10. Clinical laboratory services: | | | |
| A. Medical Technologists | 6.0 | 0.0 | ☐ |
| B. Other laboratory personnel | 3.5 | 0.0 | ☐ |
| 11. Dietary services: | | | |
| A. Dietitians | 1.0 | 0.0 | ☑ |
| B. Dietetic technicians | 0.0 | 0.0 | ☐ |

| | Full-Time Equivalent** | Full-Time Equivalent Budgeted Vacancies | Use Contract Staff in this Employee Category*** |
|---|---|---|---|
| 12. Radiological services: | | | |
| A. Radiographers (radiologic technologists) | 6.5 | 0.0 | ☐ |
| B. Radiation therapy technologists | 0.0 | 0.0 | ☐ |
| C. Nuclear medicine technologists | 1.0 | 0.0 | ☐ |
| D. Other radiologic personnel | 0.0 | 0.0 | ☐ |
| 13. Therapeutic services: | | | |
| A. Occupational therapists | 0.5 | 0.0 | ☐ |
| B. Occupational therapy assistants & aides | 0.0 | 0.0 | ☐ |
| C. Physical therapists | 0.0 | 0.0 | ☑ |
| D. Physical therapy assistants & aides | 0.0 | 0.0 | ☑ |
| E. Recreational therapists | 0.0 | 0.0 | ☐ |
| 14. Speech and hearing services: | | | |
| A. Speech Pathologist | 0.0 | 0.0 | ☐ |
| B. Audiologist | 0.0 | 0.0 | ☐ |
| 15. Respiratory therapy services: | | | |
| A. Respiratory therapists | 7.0 | 0.0 | ☐ |
| B. Respiratory therapy technicians | 1.0 | 0.0 | ☐ |
| 16. Psychiatric services: | | | |
| A. Clinical psychologists | 0.0 | 0.0 | ☐ |
| B. Psychiatric social workers | 0.0 | 0.0 | ☐ |
| C. Psychiatric registered nurses | 0.0 | 0.0 | ☐ |
| D. Other mental health professionals | 0.0 | 0.0 | ☐ |
| 17. Chemical dependency services: | | | |
| A. Clinical psychologists | 0.0 | 0.0 | ☐ |
| B. Social workers | 0.0 | 0.0 | ☐ |
| C. Registered nurses | 0.0 | 0.0 | ☐ |
| D. Other specialists in addiction and/or in chemical dependency | 0.0 | 0.0 | ☐ |
| 18. Medical Social workers | 1.0 | 0.0 | ☑ |
| 19. Surgical technicians | 1.0 | 0.0 | ☐ |
| 20. All other certified professional & technical | 11.5 | 0.0 | ☐ |
| 21. All other non-certified professional & technical | 0.0 | 0.0 | ☐ |
| 22. All other personnel | 38.0 | 0.0 | ☐ |
| TOTAL | 129.0 | 0.0 | |

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SCHEDULE K - MEDICAL STAFF*

State ID 70223

| | (1) Number of Active and Associate Medical Staff (Include Board Certified) | (2) Number of Active and Associate Medical Staff Who Are Board Certified | (3) Number of House Staff Who Are Interns, Externs or Residents |
|---|---|---|---|
| 1. MEDICAL SPECIALTIES: | | | |
| A. General and family practice | 5 | 2 | 0 |
| B. Pediatric | 0 | 0 | 0 |
| C. General internal medicine | 5 | 2 | 0 |
| D. Psychiatric | 0 | 0 | 0 |
| E. Neonatologist | 0 | 0 | 0 |
| F. Cardiologists | 2 | 2 | 0 |
| G. Neurologists | 0 | 0 | 0 |
| H. Other medical specialties | 7 | 7 | 0 |
| 2. SURGICAL SPECIALTIES: | | | |
| A. General surgery | 7 | 7 | 0 |
| B. Obstetrics and gynecology | 0 | 0 | 0 |
| C. Perinatologists | 0 | 0 | 0 |
| D. Gynecology | 0 | 0 | 0 |
| E. Orthopedic | 0 | 0 | 0 |
| F. Neurosurgeons | 0 | 0 | 0 |
| G. Cardiovascular | 0 | 0 | 0 |
| H. Gastroenterology | 1 | 1 | 0 |
| I. Other surgical specialties | 0 | 0 | 0 |
| 3. OTHER SPECIALTIES: | | | |
| A. Pathology | 1 | 1 | 0 |
| B. Radiology | 3 | 3 | 0 |
| C. Anesthesiology | 0 | 0 | 0 |
| D. Other specialties | 0 | 0 | 0 |
| 4. DENTAL SPECIALTIES: | 0 | 0 | 0 |
| TOTAL | 31 | 25 | 0 |

SCHEDULE L - PERINATAL* State ID 70223

1A. Name of person completing Perinatal survey Felicia Deal
1B. Telephone Number (423) 496-8153
1C. Fax Number (423) 496-6330

Please complete the following questions.

2. Births
   A. Total number of live births 0
   B. Birth weight below 2500 grams (5lb 8oz) 0
   C. Birth weight below 1500 grams (3 lb 5oz) 0

3. Number of babies on ventilator longer than 24 hours 0

4. Number of babies received from referring hospitals for neonatal management 0

| | YES | NO |
|---|---|---|
| 5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine? | ○ | ◉ |
| 6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal? | ○ | ◉ |
| 7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital? | | |
| A. OBSTETRICS: | | |
| Perinatal Sonologist | ○ | ◉ |
| Hematologist | ○ | ◉ |
| Cardiologist | ○ | ◉ |
| B. NEONATAL: | | |
| Pediatric Radiologist | ○ | ◉ |
| Pediatric Cardiologist | ○ | ◉ |
| Pediatric Neurologist | ○ | ◉ |
| Pathologist | ○ | ◉ |
| Pediatric Surgeon | ○ | ◉ |

SCHEDULE M - SURVEY ON NURSING PERSONNEL* State ID 70223

(As of the last day of the reporting period)

1. Registered Nurses

| HIGHEST EDUCATION LEVEL | FTE NUMBER CURRENTLY EMPLOYED | NUMBER OF BUDGETED VACANCIES | NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS | NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS | PRIMARY ROLE (NUMBER OF POSITIONS) | |
|---|---|---|---|---|---|---|
| | | | | | CLINICAL | ADMINISTRATIVE |
| Total | 25.5 | 0.0 | 0.0 | 0.0 | 24.5 | 1.0 |
| Bachelors Degree | 3.0 | 0.0 | 0.0 | 0.0 | 3.0 | 0.0 |
| Associate Degree | 22.5 | 0.0 | 0.0 | 0.0 | 21.5 | 1.0 |
| Diploma | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Masters Degree | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Doctorate Degree | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

2. Advanced Practice Nurses

| NURSING PERSONNEL CATEGORY | FTE NUMBER CURRENTLY EMPLOYED | NUMBER OF BUDGETED VACANCIES | NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS | NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS | PRIMARY ROLE (NUMBER OF POSITIONS) | |
|---|---|---|---|---|---|---|
| | | | | | CLINICAL | ADMINISTRATIVE |
| Total | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Nurse Practitioner | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Clinical Nurse Specialist | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| CRNA | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Certified Nurse Midwife | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

3. Licensed Practical Nurses

| LPNs | NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS | NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS |
|---|---|---|
| Total | 0.0 | 0.0 |

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

| NURSING PERSONNEL CATEGORY | FTE NUMBER CURRENTLY EMPLOYED | NUMBER OF BUDGETED VACANCIES | NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS | NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS |
|---|---|---|---|---|
| CCU/ICU | 0.0 | 0.0 | 0.0 | 0.0 |
| ER | 0.0 | 0.0 | 0.0 | 0.0 |
| Other (Specify): | | | | |
| | 0.0 | 0.0 | 0.0 | 0.0 |
| | 0.0 | 0.0 | 0.0 | 0.0 |

The Health Consumer Right-to-Know Act of 1998 which was signed by Governor Sunquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

BCBS OF GEORGIA
BCBS OF TENNESSEE
- BLUE CARE
- BLUE PREFERRED
- BLUE SELECT
- BLUE HMO
BCBS OF TENNESSEE - SWING BED FACILITY
- BLUE CARE/TENNCARE SELECT
- BLUE PREFERRED
- BLUE SELECT
- COVER KIDS
AETNA
AARP
SMART VALUE CLASSIC
ACORDIA NATIONAL
CIGNA
- HMO
- PPO
- OPEN ACCESS PLUS
CONTINENTAL LIFE INS CO
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MOHAWK CARPET
BENEFIT ADMINISTRATIVE SYSTEMS, LLC
TRI-STATE/CBA - COOPERATIVE BENEFITS ADMIN
TRI-CARE
UNICARE
ALLIANT HEALTH PLAN
UNITED HEALTHCARE
- AMERICHOICE
- UNITEC HEALTHCARE HMO
- UHC OF RIVER VALLEY
ADVANTRA FREEDOM
PYRAMID LIFE INS
CARITEN
UNIVERSAL HEALTHCARE
HUMANA
SECURE HORIZONS
CARE IMPROVEMENT
MEDICAID - GEORGIA
MEDICAID - FLORIDA
MEDICAID - NORTH CAROLINA
MEDICARE (HOSPITAL AND SWING BED)
TENNCARE
WELLCARE HEALTH PLAN INC. - GEORGIA HEALTH FAMILY - CMO
AMERIGROUP - GEORGIA
BEECH STREET
PEACH STATE HEALTH PLAN - GEORGIA HEALTH FAMILIES
WINDSON HEALTH